STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/20/11 Facility Number: 000192 Provider Number: 155295 AIM Number: 100291120 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Clinton House Health and Rehab Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (200) construction and was fully	K0000	This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared an d/pr executed solely because it is required by the provisions of federal an d state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 88 residents and had a census of 61 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by: Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 04/21/11.			
K0025	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
SS=E	Based on observation and interview, the facility failed to ensure openings through ceiling and wall smoke barriers in 2 of 6 smoke compartments were protected with approved materials to maintain the smoke resistance	K0025	K-025--(1)It is the policy of this facility that smoke barrier are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. (2)All residents have the potential to be affected.(3)The Maintenance Supervisor has sealed the identified penetration with a fire block sealant.(4)After	04/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 20 or more residents in 400 hall and center smoke compartment housing the main dining room. Findings include: Based on observations with the maintenance director on 04/20/11 between 12:00 p.m. and 3:30 p.m.: a. A four inch section of drywall cut out in the attic smoke barrier between the 400 hall and center smoke compartment to allow the passage of a bundle of cable was unsealed leaving a gap of two inches; b. A one inch hole between the attic and electrical/mechanical room		contactors have been performing work in the facility the Maintenance Supervisor will conduct a visual check to ensure any and all penetrations are sealed and will present findings to the monthly QA&A meeting for review and follow up.-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ceiling in the center smoke compartment was unsealed; c. Two, one inch conduit penetrations into the attic above the electrical/mechanical room in the center smoke compartment were unsealed leaving half inch annular gaps; d. Two conduit penetrations into the attic above the electrical/mechanical room in the center smoke compartment were sealed with an unapproved expandable foam. The maintenance director agreed at the time of observations, penetrations had not been properly taken care of. 3.1-19(b)			
K0029	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
SS=E	Based on observation and interview, the facility failed to provide an automatic closer for	K0029	K-0029---(1)It is the policy of t his facility to provide one hour fire rated construction or an approved automatic fire extinquishing	04/28/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the door providing access to 1 of 8 hazardous areas such as an equipment storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and more then 20 residents in the main dining room smoke compartment. Findings include: Based on observation with the maintenance director on 04/20/11 at 2:05 p.m., the door separating the six by ten foot wheel chair storage room near the 400 hall nurses station had no self closing device. The maintenance director said at the time of observation, he didn't realize the door was required to self close.		system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas.(2)All residents have the potential to be affected. (3)The Maintenance Supervisor has installed a automatic self-closure on the equipment storage room.(4)The Mainenance Supervisor will monitor doors to storage/hazardous areas for compliance during monthly safely tour going forward and will present findings to the monthly QA&A Meeting for review and follow up.	
K0048 SS=F	3.1-19(b) There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview the facility failed to	K0048	K-0048---(1)It is the policy of this facility to provide a written plan for the protection of all residents and	04/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure the facility fire plan provided effective staff training for the protection of 64 of 64 residents. This deficient practice could affect all occupants. Findings include: Based on review of the facility fire safety procedures with the maintenance director on 04/20/11 at 1:25 p.m., a Fire Policy and Procedure and Battery Smoke Alarms in Resident's Rooms Fire Policy & Procedure were provided to evidence the facility response to fire. Item E for both documents referred to, "Extinguish if the fire is small". Additionally, the procedures did not include directions to evacuate the smoke compartment. The maintenance director said at the time of record review there was no specific training for staff to discern the size of a fire. He said, "a fire is a fire", he was responsible for providing training and he did not make a distinction regarding fire size during training. In addition, he said he trained staff to evacuate residents "behind fire doors" though it was not		for their evacuation in the event of an emergency.(2)All residents have the potential to be affected. (3)The facility Fire Policy and Procedure and the Battery Smoke Alarm on Residents Room Fire Policy & Procedure has been adjusted to coincide with the inservice training staff receive and reads "evacuate the fire" and "evacuate beyond the fire doors immediately".(4)Staff have been provided copies of the recent wording adjustment made in these policies. The Maintenance Supervisor will continue to provide inservicing to staff according to policy on hire and at a minimum of annually thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	addressed in the procedure. He said he did not write policy. 3.1-19(b)			
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 7 or more resident in the physical therapy smoke compartment. Findings include: Based on observation with the maintenance director on 04/20/11 at 2:15 p.m. a power strip extension cord provided power to a coffee pot, toaster and a physical therapy hydrocolator in the physical therapy department. The power strip dangled off the side of the counter where the	K0147	K-0147---(1)It is the policy of this facility to ensure flexible cords are not used as a substitute for fixed wiring. (2)All residents have the potential to be affected.(3)The Maintenance Supervisor promptly removed the power strip and conducted a thorough tour throughout the facillity to ensure no other power strips were in place and utilized inappropriately. (4)The Maintenance Supervisor will monitor use of power strips monthly on tour of th e facility going forward and will present findings to the monthly QA&A meeting for review and follow up.	04/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	toaster and coffee pot sat. It was held by the appliances plugged into the power strip with the added weight of the hydrocolator cord. The maintenance director said at the time of observation, he was unaware the power strip was not to be used for medical equipment and he would not have permitted the power strip use in a manner which could cause electrical arcing. 3.1-19(b)			